

# PRE-TRAVEL HEALTH QUESTIONNAIRE

## KARORI MEDICAL CENTRE

### Personal details and contact information:

Name:	Your country of origin:
Date of birth:	Registered at KMC <input type="checkbox"/> Casual Patient <input type="checkbox"/>
E-mail:	Telephone number:

### Information about your trip:

Date of departure:	Total length of trip:
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### Destinations:

Country to be visited in order of travel (Include any planned transits)	Exact location/region (if known)	City/Rural	Length of stay
1.			
2.			
3.			
4.			
5.			
6.			

**Type of Travel and Purpose of Trip:** (please tick all that apply)

<input type="radio"/> <b>Holiday</b> <input type="radio"/> <b>Business</b> <input type="radio"/> <b>Volunteer work</b> <input type="radio"/> <b>Healthcare worker</b> <input type="radio"/> <b>Expatriate</b> <input type="radio"/> <b>Medical tourism</b> <input type="radio"/> <b>Pilgrimage</b> <input type="radio"/> <b>Visiting Friends and Family</b>	<input type="radio"/> <b>Resort/Hotel</b> <input type="radio"/> <b>Cruise-ship</b> <input type="radio"/> <b>Camping</b> <input type="radio"/> <b>Backpacking/hostels</b> <input type="radio"/> <b>Staying with friends/family</b>	<input type="radio"/> <b>Adventure</b> <input type="radio"/> <b>Trekking</b> <input type="radio"/> <b>Climbing</b> <input type="radio"/> <b>Diving</b> <input type="radio"/> <b>Safari</b>
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**Vaccination History:** (please supply information on any immunisations or anti-malaria medication you have had in the past please note if previously vaccinated at KMC we will have this information on your medical records)

Vaccine	Date	Vaccine	Date	Vaccine	Date
Tetanus/Diphtheria		Hepatitis A		Rabies	
Polio		Typhoid		Yellow Fever	
Measles/Mumps/Rubella		Cholera		Meningococcal ACWY	
Hepatitis B		Pneumococcal 13		Meningococcal B	
Whooping cough		Influenza		Japanese Encephalitis	
Covid-19 Primary course Booster		Pneumococcal 23		Shingles	

Malaria tablets name if previously used:	Date:

**Medical History** (please supply details of any current or previous conditions)

<b>Do you currently or have you had</b>	<b>Yes</b>	<b>No</b>	<b>Details</b>
Any allergies (including to food/latex/medications)			
Severe reaction to a vaccine			
Fainting episodes with injections/blood tests			
Any surgical procedures			
Recent chemo/radio therapy or organ transplant			
Bleeding/clotting disorders (including DVTs)			
Any long-term conditions including diabetes, heart disease, respiratory (lung) problems, epilepsy/seizures or other neurological conditions, liver or kidney problems, HIV/AIDS or other immune system conditions, including spleen problems, rheumatology problems etc)			
Mental health issues, including anxiety, depression			
Any other conditions			
<b>Women only</b> Are you pregnant/breastfeeding/planning pregnancy			

**Medication:** (please list details of all prescribed, purchased over-the-counter, and contraceptive medication, note if you are a registered patient at KMC we will have these details on your medical record)

Please complete the questionnaire as fully as possible and return via email to [mary.mccaffrey@kmc.co.nz](mailto:mary.mccaffrey@kmc.co.nz). Once we have reviewed your questionnaire we will contact you regarding an appointment. Your request may be prioritised depending on the departure date given and recommendations advised for your individual trip. If your request is urgent, please call Karori Medical Centre 04 9204562 to advise our staff of this.